Balancing community-based and hospital-based mental health care

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In the last two decades of the 20th century, there has been a debate between those who were in favour of the provision of mental health treatment and care in hospital and those who preferred to use primarily or even exclusively community settings, where the two were often seen as incompatible. This paper summarises the evidence on the advantages and limitations of these two perspectives, and concludes that this false dichotomy should be replaced by a model, in which balanced care includes both modern community-based and modern hospital-based care. We shall focus on the mental health needs of adults of working age, and the range of services necessary to meet these needs (1). We shall not directly address the needs of other important groups, including children, older adults, or people suffering primarily from drug or alcohol misuse.

Mental health services in many countries are subject to change. They are now being reviewed and redesigned. These changes reflect in part the growing evidence of what constitutes cost-effective care, and are also an acknowledgement of the failures of the systems of care which were based on the old-fashioned and remote institutions. These asylums did not offer the quality of care that is expected today, both by patients and by their families. There is also now an increasing worldwide focus upon the chronically disabling conditions, including mental disorders. This is reflected in attention not only to mortality, but also to a wider concept of morbidity and global burden of disease, which goes beyond symptoms to attach importance to disability, quality of life, satisfaction with services, and impact on care givers.

A note is needed here on terminology, as we shall describe this new balanced care as the combination of a) services in a wide range of local sites and settings outside hospital, including non-hospital long-term residential care (*modern community care*), and b) services providing acute inpatient treatment, often in general hospital units (*modern hospital-based care*). In balanced care the focus is upon services provided in normal community settings, as close to the population served as possible, and in which admissions to hospital can be arranged promptly, but *only* when necessary. By contrast, the practices and orientation associated with the old, large psychiatric institutions may be described as *traditional hospital care*.

THE HISTORICAL BACKGROUND

The recent history of mental health services can be seen in terms of three periods: first, the rise of the asylum; second, the decline of the asylum; and third, balancing mental health services (2). It is important to note that although the three historical periods usually occur consecutively, the times at which they began and finished in different countries varied considerably. Table 1 shows the key characteristics of each historical period.

Period 1. The rise of the asylum

Period 1, the rise of traditional hospital care, occurred between approximately 1880 and 1950 in many of the more economically developed countries (3). It was characterised by the construction and enlargement of asylums, remote from their populations, offering mainly custodial containment and the provision of the basic necessities for survival, to people with a wide range of clinical disorders and social abnormalities. The consequences of this choice of remote locations were segregation of patients as well as the subsequent professional segregation of psychiatrists and nurses from the main body of clinical practice, and from the centres of professional status in the metropolitan, university teaching hospitals. There is now strong evidence that the asylum model has produced very poor standards of treatment and care (4). Despite this, in some countries, especially those which are less economically developed, almost all mental health service expenditure continues to pay for asylum care.

Period 2. The decline of the asylum

Period 2 has taken place in many economically developed countries after about 1950, since when manifest system shortcomings were repeatedly demonstrated. These recurring themes, associated with the failures of asylums, are: a) repeated cases of ill-treatment to patients; b) the geographical and professional isolation of the institutions and their staff; c) poor reporting and accounting procedures; d) failures of management, leadership, and ineffective administration; e) poorly targeted financial resources; f) poor staff training; g) inadequate inspection and quality assurance procedures.

The accumulating evidence of these failures of the asylum led to the

Table 1 The key characteristics of the three periods in the historical development of mental health systems of care (according to Thornicroft and Tansella [2])

Period 1. The rise of the asylum	Period 2. The decline of the asylum	Period 3. Balancing mental services
Asylums built	Asylums neglected	Asylums replaced by smaller facilities
Increasing number of hospital beds	Decreasing number of hospital beds	Decrease in the number of beds slows down
Reduced role for the family	Increasing but not fully recognised role of the family	Importance of families increasingly recognised, in terms of care given, therapeutic potential, the burden carried and as a political lobbying group
Public investment in institutions	Public disinvestment in mental health services	Increasing private investment in treatment and care and focus in public sector on cost-effectiveness and cost containment
Staff: doctors and nurses only	Clinical psychologist, occupational therapist and social worker disciplines evolve	More community-based staff and emphasis on multidisciplinary team working
	Effective treatments emerge, beginning of treatment evaluation and of standardised diagnostic systems, growing influence of individual and group psychotherapy	Emergence of 'evidence-based' psychiatry in relation to pharmacological, social and psychological treatments
Primacy of containment over treatment	Focus on pharmacological control and social rehabilitation, less disabled patients discharged from asylums	Emergence of concern about balance between control of patients and their independence

deinstitutionalisation movement, supported by the strong evidence of 'institutionalism', which is the development of disabilities as a consequence of social isolation and institutional care in remote asylums. Deinstitutionalisation can be defined as including three essential components: a) the prevention of inappropriate mental hospital admissions through the provision of community facilities; b) the discharge to the community of long-term institutional patients who have received adequate preparation (5); c) the establishment and maintenance of community support systems for non-institutionalised patients.

It is instructive to compare deinstitutionalisation in the USA and in the UK. In the USA the reduction in the numbers of long-stay hospital beds occurred mainly in the period between 1960 and 1980, and is considered in many states to have been unsatisfactory. This is due in part to the fact that community mental health centres, organised to provide for discharged long-term patients, instead came to serve a new population of patients, previously either receiving no care, or treated in non-specialist settings, while patients discharged en masse from psychiatric hospitals were either abandoned or transferred to smaller institutions, often private, which frequently provided a poor quality of care ('transinstitutionalisation').

By comparison, when deinstitutionalisation is more carefully planned and managed, then the evidence is that the outcomes will be favourable for almost all the discharged patients (6). The Team for the Assessment of Psychiatric Services (TAPS) study in London (4), for example, completed a five-year follow-up on over 95% of 670 long-stay non-demented patients discharged from Friern and Claybury hospitals, and found: a) at the end of five years, two thirds of the patients were still living in their original residence; b) reprovision did not increase the death rate or the suicide rate; c) fewer than 1 in 100 patients became homeless, no patient was lost to follow-up from a staffed home; d) over one third were readmitted during the follow-up period; at the time of follow-up 10% of the sample were in hospital; e) overall, the patients' quality of life was greatly improved by the move to the community, but disabilities remained due to the nature of severe psychotic illnesses; f) there was little difference overall between hospital and community costs: coupled with the outcome findings, the economic evaluation suggests that community-based care is more cost-effective than long-stay hospital care.

Period 3. Balancing mental health care

Period 3 refers to the stage in which the main goal is to develop a range of *balanced care* within local settings. In this process, which has not yet begun in some regions and countries, it is important to ensure that all the positive functions of the asylum are fully reprovided, and the negative aspects of the institutions are not perpetuated. The range of functions of these institutions are summarised in Table 2, along with the effects of transferring the functions from traditional hospital care to balanced care.

One of the implications of developing the balanced care approach is a fundamental reorientation of staff attitudes (Table 3).

The balanced care approach aims to provide services which offer treatment and care with the following characteristics: a) services which are close to home, including modern hospital care for acute admissions, and long-term residential facilities in the community (7); b) interventions relat-

Table 2 Functions of traditional hospital care and the effect of transferring these functions to balanced care

Function of traditional hospital care	Effect of transferring function to balanced care
Active treatment for short to intermediate stay patients	Function maintained or improved, but results from community care programmes may not be generalisable
Long-term custody for patients	Function usually improved in residential homes for those who need long-term high support
Physical assessment and treatment	Function may be better transferred to primary care or general health services
Protection of patients from exploitation	Function may be impaired: some patients continue to be vulnerable to physical, sexual and financial exploitation
Respite for family and carers	Function usually unchanged: place of treatment at home is offset by potential for increased professional support to family
Research and training	Function decentralised: new research and training opportunities arise
Provision of day care and outpatient services	Functions are decentralised and may be improved if more local and accessible services are developed or may deteriorate if they are not established; renegotiation of responsibilities is often necessary between health and social care agencies for day care and occupational services
Secure provision for assaultative patients	Function vulnerable: clear commitment needed to provide well staffed units for dangerous patients
Occupation, vocational and rehabilitation services	Function improved in normal settings
Shelter, clothing, nutrition and basic income	Functions decentralised and at risk, so responsibilities and co-ordination must be clarified

Table 3 Comparison of staff attitudes and orientation in traditional hospital care and balanced care

	Traditional hospital care orientation	Balanced care orientation
Staff attitudes	Routine contacts with patients Focus on control and structure Use of policies and procedures Hierarchical decision making	Unplanned responses Family focus Emphasis on social disability Negotiation approach
Staff training	Biological orientation Training rotates between specialist units for diagnostic groups	Eclectic orientation and problem solving approach Training rotates between specialist teams
Therapeutic orientation	Emphasis on symptom relief Improved facilities and expertise for physical assessment, investigation, procedures and treatment Brief assessment package Seek decision from above in the hierarchy Control for suicidal/violent patients Block treatment of patients groups Regulated timetable Separated short-term treatment and rehabilitation	Greater staff independence Longer term assessment process More individual treatment May neglect physical diagnosis and treatment Integrated therapeutic and social interventions

ed to disabilities as well as symptoms; c) treatment and care specific to the diagnosis and needs of each individual; d) services which reflect the priorities of service users themselves; e) services which are co-ordinated between mental health professions and agencies; f) mobile rather than static services, including those which can offer home treatment.

The historical development of mental health services is, however, not a consistent trend from traditional hospital care to balanced care. Many contradictions occur and every country shows examples of phases of evolution and regression.

A FRAMEWORK FOR PLANNING BALANCED MENTAL HEALTH CARE

Having assessed the scale of need for treatment, how can one plan the services necessary to respond to the need? A conceptual model can be useful to formulate such service plans. One example is the 'matrix model', which has two dimensions: the geographical and the temporal. The first refers to three geographical levels: 1) country/regional; 2) local and 3) individual. The second dimension refers to three temporal levels: A) inputs (the resources which are used); B) processes (how the resources are utilised) and C) outcomes (the results obtained). Using these two dimensions, a 3 x 3 matrix can be constructed as shown in Table 4. Whatever the precise local service configuration used, it is our contention that the most important issue is to optimise the outcomes for individuals with mental health problems (cell 3C).

ASSESSING NEEDS FOR SERVICES AND FOR TREATMENTS

Assessing needs at the country/regional level or at the local level

To assess the level of need for treatments and care for mental health problems at the country/regional or at the local levels, it is important to appreciate how common mental illnesses are, and to understand the pathways that patients can follow to seek care. The well-known Goldberg

Table 4 The 'matrix model' (according to Thornicroft and Tansella [2])

Geographical dimension	Temporal dimension		
	(A) INPUT PHASE	(B) PROCESS PHASE	(C) OUTCOME PHASE
(1) COUNTRY/REGIONAL LEVEL	1A	1B	1C
(2) LOCAL LEVEL (CATCHMENT AREA)	2A	2B	2C
(3) INDIVIDUAL LEVEL	3A	3B	3C

Table 5 Implications of the levels and filters scheme

- Mental illnesses are common, affecting up to a quarter of the adult population each year
- Most cases are only seen in primary care, and are often not detected
- Training primary care and general health care staff in the detection and treatment of common mental disorders is an important public health task
- This training is facilitated by liaison with local community-based mental health staff, and is uncommon if psychiatrists work in isolated institutions and do not transfer their expertise
- Specialist mental health staff and resources should be concentrated upon the most severely mentally ill, who have complex needs and who may develop chronic and severe disabilities if not treated
- The quality and quantity of specialist mental health services needed is critically dependent upon the services which are provided at the primary care
- To understand the way a mental health system works, and how it can be improved, one needs to know the occurrence of morbidity at the five levels (cross-sectional), and the relative permeability of the four filters (longitudinal)
- The provision of services at level 4 needs to be balanced between community care and hospital care

and Huxley scheme (8) describes five levels, separated by four filters, and represents the relationship between total psychiatric morbidity in the general population (level 1), the proportion who are seen in primary care (level 2), those who are recognised by primary care staff as having a mental disorder (level 3), those who are seen by specialist mental health staff (level 4), and finally those who are admitted to psychiatric beds (level 5).

This scheme is fundamental to an understanding of how to plan and provide mental health services on the basis of the frequency and severity of mental disorders. The implications of this approach are summarised in Table 5. Nevertheless, the scheme is an oversimplification of the actual pathways to and through care that occur in any specific place, since some patients will refer themselves directly to mental health staff, while others will be referred by long and indirect pathways (9). The pathways taken will also be largely constrained by the services available in each country or region, and by culture-specific patterns of help-seeking behaviour.

As specialist services are scarce and expensive, they should *target* their skilled impact upon for: a) undertaking the assessment and diagnosis of complex cases, and those requiring an expert second opinion; b) treating people with the most severe symptoms; c) providing care for those with the greatest degree of disability consequent from mental illness; d) making treatment recommendation for those conditions which have proved non-responsive to initial treatment.

To achieve this consistently, a service will need to identify *priority* groups of those who should receive access to specialist care, from among the 25% of the whole population who suffer from a mental disorder in any year. In our view *well targeted* services are those in which specialist care *concentrates* upon providing direct services to people with the most severe degrees of symptoms and disability. This means treating, to a high clinical standard of evidence-based care, both psychotic and non-psychotic severe disorders, in the acute and post-acute phases. Moreover, they should offer consultation, liaison and advice to primary care and other services which treat the more common mental disorders, with a special responsibility for the treatment-resistant and more chronically disabling mental disorders seen in those settings (10).

Assessing needs at the individual level

A reasonable starting point in planning mental health services is to provide them in relation to the *specific* needs of people with mental health problems in the local area. One of the most important developments in mental health in recent years has been the change from seeing patients solely in diagnostic categories, to a consideration of their specific disabilities and individual needs, including, for example, for housing, work and social relations. The focus of service planning and provision is now required to change accordingly.

Traditional hospital care often provided interventions in many of the following six areas: mental health, social life, physical health, accommodation, occupation and money. However, they were provided in an undifferentiated form as block treatment, not specific to individual patients, and sometimes in excessive 'dose'. For example, by being provided with meals who could cook for themselves if given the opportunity, patients were

disabled from exercising autonomy. In addition, patients within asylums were isolated from their natural communities, were restricted in many aspects of their basic autonomy, had weakened social networks, and so were offered a poorer quality of life.

Each of the above six domains can also guide service planning at the local level. If need is defined as the ability to benefit from treatment and care, then what is the evidence that these interventions for mental disorders are effective and can meet needs? An example of interventions in one domain of need will be illustrated here: occupation.

Evidence of treatment effectiveness for occupational interventions

It is clear that in many countries people suffering from mental disorders have profound disabilities in terms of their employment and occupation, and for example up to 95% of people with schizophrenia are unemployed in many economically developed nations. The available evidence (11-13) suggests that: a) supported employment schemes (which consist of arranging early placement in normal work with variable support from staff) may offer better outcomes than sheltered or transitional employment approaches; b) supported employment is more effective than pre-vocational training for patients suffering from a severe mental disorder who want to work; c) there is no evidence that pre-vocational training is more effective than standard community care or hospital care; d) most vocational rehabilitation programmes have a positive influence on work-related activities, but may have less success in enabling patients to gain and keep paid employment; e) vocational rehabilitation may also produce benefits on such clinical outcomes as medication compliance, symptom reduction and relapse.

The implication of these findings is that people suffering from mental disorders who want to work should be offered the option of supported employment (14,15). On the other hand, vocational rehabilitation should be offered for those people who have any of the following characteristics: a) identify competitive employment as a personal goal; b) have a history of prior competitive employment; c) have a history of minimal psychiatric hospitalisation; d) are judged from formal vocational assessment to have good work.

The components of balanced care at the local level

What are the implications of this balanced care approach for how and where mental health services should be provided at the local level? Since balanced care includes both modern hospital beds (or suitable alternatives), and community facilities and resources, what pattern of care is necessary, and where should be the focus of care?

The pattern of care refers to the relative availability of services in the five main categories in the basic service profile, reported in Table 6. The meaning of this profile is to emphasise that sufficient services will need to be provided in *all* of these five categories. One, therefore, has to address the *capacity* needed for *each* of these categories, taking into account the services that are available in all the other categories, and this orientation is sometimes called *whole system planning*.

The *focus of care* refers to the relative importance attached to hospital care compared with community care. During the second historical period (the decline of the asylum), the focus of care was still considered to be the hospital, supplemented by services in the community, which were then called 'complementary'. The successful implementation of balanced care implies a change in the centre of gravity, so that modern hospital care is seen as only one component of a wider range of provisions serving a whole community or population. In practical terms, this means that psychiatrists and other mental health staff working in community settings need to have access to modern hospital beds, when treatment options in the community are not sufficient to offer urgent clinical investigations, or to provide intensive support during periods of crisis.

The basic service profile applies to many countries which provide mental health services at both the primary and secondary care levels. For emerging market economies, in which services may be limited to primary care with few beds in psychiatric hospitals, the basic service profile offers a template to redesign a new service system.

Key interfaces for mental health services

While the specific service components necessary in each local area will vary according to local circumstances, there is a common need for communication within these components and between the service and other agencies. Compared with a hospital care system, the quality of communication is different in balanced care because: a) hospitals used more hierarchical systems of communication, with less emphasis upon collaboration; b) in hospital care a single agency usually provides all the services, while in balanced care the functions are separated and decentralised to many different well-coordinated agencies; c) face-to-face contact between staff in different teams is less common.

The implication of these aspects of balanced care is that particular attention needs to be paid to maintaining high quality communication between all parts of the care system. The experience of areas which have begun to introduce the balanced care model shows the need to address three types of *interface*: a) those *within the mental health service*, between its components; b) those *within the health service*, between mental health and other services (both primary and secondary care); c) those *between health*

Table 6 The basic service profile of balanced mental health care

Basic service component	Variations
1. Primary care and general hospital consultation, outpatient and mobile community services (including home visits)	Mobile services for assertive community treatment (including evening and weekend services) Outpatient services for specific disorders or for specialised treatments
2. Day care services (including occupational/vocational rehabilitation)	Sheltered workshops Supervised work placements Co-operative work schemes Self-help and user groups Advocacy services Training courses Club houses/traditional employment programmes
3. Interfaces with other services (e.g. health, social and non-governmental agencies)	*Health services* Forensic services Old age services Learning disability/mental handicap services Specialised psychotherapies General physical and dental health Consultation to primary care/general practitioners *Social services/Welfare benefits* Income support Domiciliary care (e.g. cleaning) Holiday/respite care *Housing agencies* Unsupervised housing/apartments *Other government agencies* Police Prison Probation *Non-government agencies* Religious organisations Voluntary groups For-profit private organisations
4. Acute inpatient services and equivalents	Specialised units for specific disorders (e.g. intensive care and forensic) Acute day hospitals Crisis houses
5. Longer-term residential services	Unsupervised housing with administrative protection Supervised housing (boarding out schemes) Unstaffed group homes Group homes with some residential or visiting staff Hostels with day staff Hostels with day and night staff Hostels and homes with 24 hours nursing staff

and other public services, including social services and the housing departments. A first requirement is to clarify the ways in which the separate mental health service components operate together as a system.

CONCLUSIONS

This paper is intended to help close the gap between what we know about effective mental health services and what we do. The growing influence of evidence-based medicine now means that we have a much clearer idea than ever before about which treatments, at the individual level, and which types of service, at the local level, have been shown to be effective, or cost-effective. The balanced care orientation described here creates a number of new challenges to planners and providers of services. It takes us beyond the sterile rhetoric about whether hospital care *or* community care is better, to consider what *blend* of these ingredients is most appropriate for a particular local area at a particular point in time. This means that an assessment of local needs must be undertaken to inform such planning decisions. Other key influences upon the quality and quantity of mental health service provision are economic factors, for example the proportion of total health resources which are dedicated to mental health care. This allocation is in turn determined not only by the overall national economic situation, but also by ethical and political considerations. The relationship between economics and mental health needs to be taken into account during the planning process. Differences between economically developed and developing countries in terms of availability of specialist services, and culture-specific patterns of help-seek-

ing behaviour, and changes over time according to economic cycles confirm the importance of that relationship (16).

A further challenge to professionals is the increasing call from service users and from carers to be directly involved in defining what local needs are, and which needs are the highest priority. The growth of this trend is such that a greater degree of consumer power is likely to be seen in future in both the planning and provision of services in many different cultures and contexts. This will influence the demand for the particular mixture of treatment and care. Indeed, the involvement of non-professionals is likely also to grow as a series of stakeholders insist on representation and involvement in planning mental health services. These may include local housing departments, churches, neighbourhood and community associations, local politicians, newspaper, radio and television reporters, and police officers.

The process of deinstitutionalisation has usually meant the closure of long-stay beds in the larger psychiatric institutions, and there is now strong evidence, for the large majority of such patients, that community-based residential care offers such people a higher quality of life. Such types of residential care are usually best provided when they are small in scale, linked closely to the other components of a balanced care system, and when they are developed gradually over time as the nature of local needs emerges. Further to this there is now growing evidence that some types of community-based alternative to acute hospital admission may also be cost-effective, such as crisis houses and home based treatment by community mental health teams, and such innovative services are likely to become more common in the coming years.

The new agenda described in this paper goes beyond traditional polarised views to invite a participatory approach to developing better mental health services. This model of balanced care needs to be flexible to adapt to changing circumstances, and the potential for such flexibility is indeed an advantage, compared to the rigidity of hospital based care. This ability to respond to the changing mental needs of local populations is likely to become even more important in the coming years because of the unpredictable results of futures cycles of planning and evaluation.

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